Functional Rating Index
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.
For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity
   - 0: No pain
   - 1: Mild pain
   - 2: Moderate pain
   - 3: Severe pain
   - 4: Worst possible pain

2. Sleeping
   - 0: Perfect sleep
   - 1: Mildly disturbed sleep
   - 2: Moderately disturbed sleep
   - 3: Greatly disturbed sleep
   - 4: Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)
   - 0: No pain; no restrictions
   - 1: Mild pain; need to go slowly
   - 2: Moderate pain; need some assistance
   - 3: Severe pain; need 100% assistance

4. Travel (driving, etc.)
   - 0: No pain on long trips
   - 1: Mild pain on long trips
   - 2: Moderate pain on long trips
   - 3: Severe pain on short trips

5. Work
   - 0: Can do usual work
   - 1: Can do 50% of usual work
   - 2: Can do 25% of usual work
   - 3: Cannot work
   - 4: Can do usual work; plus unlimited extra work

6. Recreation
   - 0: Can do all activities
   - 1: Can do most activities
   - 2: Can do some activities
   - 3: Can do a few activities
   - 4: Cannot do any activities

7. Frequency of pain
   - 0: No pain
   - 1: Occasional pain; 25% of the day
   - 2: Intermittent pain; 50% of the day
   - 3: Frequent pain; 75% of the day
   - 4: Constant pain; 100% of the day

8. Lifting
   - 0: No pain with heavy weight
   - 1: Increased pain with heavy weight
   - 2: Increased pain with moderate weight
   - 3: Increased pain with light weight
   - 4: Increased pain with any weight

9. Walking
   - 0: No pain; any distance
   - 1: Increased pain after 1 mile
   - 2: Increased pain after 1/2 mile
   - 3: Increased pain after 1/4 mile
   - 4: Increased pain with all walking

10. Standing
    - 0: No pain after several hours
    - 1: Increased pain after several hours
    - 2: Increased pain after 1 hour
    - 3: Increased pain after 1/2 hour
    - 4: Increased pain with any standing

Name ________________________________

PRINTED ________________________________

Signature ________________________________

Total Score ________________

Date ________________________________

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